2018 New Proposed Rules for MACRA
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MACRA: Bottom Line

1. Likely to stay (bipartisan, bicameral support)
2. Impacts any services billed under Medicare Physician Fee Schedule
3. First “performance period” began January 1, 2017
4. Hospitals must prepare for increased data collection and quality assessment
5. Hospitals must educate independent members of medical staff on MACRA and its implications
MACRA is here to stay

MACRA enjoys overwhelming bipartisan and bicameral support:

- Senate: 92/8 vote in favor of MACRA
- House: 392/37 vote in favor of MACRA
MACRA changes the way Medicare pays doctors

Quality Payment Program (QPP)

- Merit-based Incentive Payment System (MIPS)
  - Need to manage penalties

- Advanced Alternative Payment Models (APMs)
  - Need to manage risks
Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)
- Stay in Fee for Service
- Increase % of payment tied to value

Advanced Alternative Payment Models (APMs)
- Exit Fee for Service
- 5% lump sum of previous year’s Medicare payments
Track 1: Merit-based Incentive Payment System (MIPS)
MIPS is the default track

Combine three existing programs:

- Physician Quality Reporting Program (Quality)
- Value-Based Payment Modifier (Cost and Resource Use)
- Meaningful Use (Advancing Care Information)

New! Clinical Practice Improvement Activities

= Merit-Based Incentive Payment System (MIPS)
MIPS penalties and bonuses are budget neutral

MIPS Maximum Payment Adjustments
(Adjustment to provider’s base rate of Medicare Part B payment)

- 2019: -4%
- 2020: -5%
- 2021: -7%
- 2022: -9%
Even though MIPS is the default, not everyone needs to participate.
2018: What’s Changing for MIPS

1. New Performance Category Weights
2. New MIPS Low Volume Threshold
3. MIPS Facility-based Clinician Measurement Option
4. MIPS Virtual Group Reporting Option
5. New MIPS Bonus Points
### MIPS performance category weights change over time

<table>
<thead>
<tr>
<th>MIPS Performance Category</th>
<th>CY 2017 (Final)</th>
<th>CY 2018 (Proposed)</th>
<th>CY 2019 and Beyond (Proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (PQRS)</td>
<td>60%</td>
<td>60%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost/Resource Use (VPM)</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information (MU)</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
New MIPS Low Volume Threshold

- CMS proposes to raise the low-volume threshold.
  - Medicare billing: $30,000 --> $90,000
  - Medicare patients: 100 --> 200
- Estimated exemption of approximately 565,000 clinicians.
MIPS Facility-based Clinician Measurement Option

• To participate, clinicians must provide 75% or more of their services in an inpatient hospital setting or emergency room setting
• Quality and cost measures tied to hospital’s Value Based Purchasing (VBP) Program performance
• Deadline: March 31, 2019
MIPS Virtual Group Reporting Option

- Small practices (<10 clinicians) can report together
- Multiple NPIs as One TIN
- Performance will be aggregated
- Larger practices will fare better under MACRA
  - More resources
  - Drive 1-2 physician practice to bigger organizations to respond to MACRA challenges
- Deadline: December 1, 2017
New MIPS Bonus Points

Complex Patients
✓ Up to 3 points (applies only to 2018)
✓ Based on Hierarchical Conditions Category risk score

Small Practice
✓ Up to 5 points (applies only to 2018)
✓ For practices of 15 or fewer clinicians
Track 2: Advanced Alternative Payment Models (APMs)
CMS has specific requirements for Advanced APMs

- Use of certified EHR technology
- Tie payment to quality
- Requires downside risk

Advanced APM
Qualified Participant for Advanced APM?

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**YES**
- 25% of Medicare Part B Payments through APM
- OR
- 20% of Medicare Patients through APM
- 5% bonus from CMS
- No MIPS reporting

**PARTIAL**
- 20% of Medicare Part B Payments through APM
- OR
- 10% of Medicare Patients through APM
- Opt OUT
  - Do Nothing. No positive or negative adjustment
- Opt IN
  - Report MIPS. Potential positive adjustment

**NO**
- Report MIPS. Positive or negative adjustment
2018: What’s Changing for APMs
CMS will continue most 2017 policies for APMs

1. Proposed list of Advanced Alternative Payment Models
2. Extend “nominal” revenue at risk
3. Implement All Payer Advanced APM Determination Process
Nominal Revenue at Risk

CMS sets the total potential risk for models to be considered an advanced APM

- Extend the current nominal revenue based risk requirement of 8% for performance years 2018, 2019, and 2020
All Payer Advanced APM Determination Process

- Allows clinicians, APM entities, and payers to obtain approval for Medicaid, Medicare Advantage, and multi-payer models to qualify as advanced APMs
- This option will begin in 2021
- Similar to Medicare APMs (i.e., certified EHR technology, quality measures comparable to MIPS, bear more than nominal financial risk)
Comments on Proposed Rules

• The Adventist Health Policy Association (AHPA) is collecting comments on behalf of 85 SDA hospitals
• Comments on the proposed rule are due August 21st by 2 pm PST. AHPA needs to compile our comments by August 11th.
• For further comments or thoughts, please contact Susana Molina Molina (Susana.Molina@ahss.org) or Julie Zaiback-Aldinger (Julie.Zaiback@ahss.org)
THANK YOU!

Any other questions? helenjung@llu.edu or ihpl@llu.edu

Let us know what topics you would like for us to cover next!